Community Mental Health

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■ *The distinctive feature of a community mental health program is the comprehensive responsibility assumed for the mental health as well as the psychiatric needs of a particular area. Not only must programs provide psychiatric services but, in addition, they are concerned with assessing the community's psychiatric and mental health status; with preventive services; with mental health education; with contributions directed toward the solution of certain social problems; as well as with a variety of other indirect services, including, importantly, mental health consultation. This form of consultation can support and help the large number of community caretakers whose contribution is vital to the promotion of community mental health.*

THE RESPONSIBILITY for a specific population is the distinguishing characteristic of community mental health practice, and it is this shift of attention from concerns with the individual to the mental health needs of a community that establishes the uniqueness of the field. This responsibility extends not only to planning services for and treating members of the population who demonstrate or in some way acknowledge the presence of emotional problems, but, in addition, it also encompasses persons who are emotionally disturbed but unaware of their problem and whom the current, existing methods of psychiatric treatment are not reaching. This comprehensive responsibility pertains broadly to all ages, all types of problems, all cultural and racial groups and the members of every socioeconomic class. To further compound this responsibility, the charge is not only to provide the necessary psychiatric treatment but also to establish programs for the prevention of disease and the promotion of the mental health of the population.

In this field, a variety of social issues and problems of community living inevitably become particular concerns. These include (to cite only a few examples) alcoholism, suicide, drug addiction, delinquency, mental retardation, housing, poverty, unemployment and racial intolerance.

It is not surprising that this range of challenging responsibilities assigned to the community mental health field currently remains an unachieved ideal for most programs and that various critics have labeled these goals as grossly unrealistic, socialistic or not within the domain of legitimate mental health practice. Not ignoring the seriousness of these charges and concerns, programs continue to increase in number and importance throughout the country.

This is still a new and rapidly developing field and even the boundaries of the various subdivisions of practice remain somewhat blurred. Many people look upon *community psychiatry* and *community mental health* as synonymous terms. Others visualize community mental health as being the broader designation which includes within its scope the separate area, community psychiatry, which is primarily concerned with the treatment and management of the materialized psychiatric disorders of a community by the psychiatric professional team. From this viewpoint, community mental health is perceived as being concerned with mental health as well as mental illness, with prevention as well as psychiatric treatment; and the designation of community mental health perhaps more clearly underlines the important contribution that is

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made in this field by non-psychiatric professionals and laymen. Social psychiatry is generally regarded as having more of a research, study and theoretical orientation, as being less of an applied field than community mental health, and as concerning itself with social problems and the relevance of social system functioning to a population's mental health.

The types and sizes of communities that may constitute a "population responsibility" in the practice of community mental health are varied. In general, the boundaries of the particular community are established by geographic or functional determinants. From the geographic dimension, the community may be specified as a city, a county, a region of a state, an entire state or, in some contexts, the entire nation. *Function* can delineate populations and communities for special programs —an industrial firm, for example, or a college, an army unit or a trade union.

The responsibility of a community mental health program for a particular population is generally established by a formal contract or a job assignment of one kind or another. This may originate out of separate or combined federal, state or local community mental health service legislation or through private contracts. Each contract should detail the responsibilities to be assumed. Obviously, programs are not imposed upon communities. Rather, all community programs should originate from the population's request for services, and the success of any program will be determined by the community's continued interest and participation in the planning and operation of the enterprise.

The major responsibility assumed by any community mental health program is the charge to reduce the incidence of mental disorder in the population as well as to decrease the amount of disability and defect resulting from mental illness.

At present there is no tried and validated model program or approach which has demonstrated that it can conclusively accomplish a reduction in the incidence of mental disorder in a community. Indeed, psychiatry in general lacks this type of validated evidence for the effectiveness of its treatment approaches. But a significant amount of research and study is being conducted, and it may be that at some future time a validated program model for community mental health intervention will be available. It may be well to mention here that mental health professionals are not maintaining that they have available answers or solutions to the numerous social problems confronting communities or that these eventual solutions will necessarily call for contributions from the field of mental health. The mental health profession in general remains as unsure about coping with these issues as are any of the other agencies and individuals in the community. Above all, there is no wish to contaminate the important helping roles of teachers, police, social agencies and many other community workers by having them assume a pseudopsychiatric stance. However, a responsibility clearly remains to be interested in, concerned about and actively participating with others in exploring possible approaches and solutions to these important problems.

The acknowledged absence of a validated approach for lowering the incidence of mental illness in a community does not mean that we lack programs which can with considerable conviction be recommended to communities, nor does it warrant waiting to move into community mental health planning until the tested model emerges. Rather, the present situation necessitates that introduction of programs, program evaluation and community-based mental health research be conducted concurrently.

To describe the various activities and services that would be included in an "average" community mental health service program would be an exhausting assignment. Perhaps it will suffice to note that these responsibilities generally fall into the following very broad and obviously incomprehensive categories:

- Activities relating to the assessment and definition of the particular community's mental health needs and the maintenance of a continuing functional record of information and data.
- Direct treatment services to the identified psychiatric patients in the population.
- Indirect consultative services designed to support and assist various community caretakers in their work, which is of great importance to the mental health of the community.
- Services and programs whose goals are the prevention of mental illness as well as the promotion of mental health or mental health education.
- The services and contributions the program provides with reference to special social and community problems perceived as being intimately related to mental health or mental illness.

- The various administrative, coordinative and program evaluation systems necessary for the successful operation of the program.
- Professional and non-professional training.
- Research programs of all types.

The psychiatric treatment offered by the direct service component of community mental health programs characteristically emphasize a crisis or a short-term therapeutic approach. The goal of the therapy is the resolution of a current crisis or disequilibrium with a quick return of the patient to a functional role in the community. The treatment goals advocated by most programs, which by now verge upon professional slogans, include:

- Psychiatric treatment available at the point in time when the problem presents.
- Treatment within the environs of the individual's familiar neighborhood and community.
- Availability of the variety of different types of service as needed—that is, comprehensive care. Included, therefore, should be opportunities for 24-hour care, day hospital programs, outpatient and emergency treatment, and a number of transitional and after-care programs. To construct such a network of comprehensive care requires that private or public treatment components already operative in the community be creatively involved and utilized in the mental health program.
- Insure continuity of professional team members and familiar helpers throughout the course of treatment, irrespective of the different approaches employed.
- Return the patient to a functional role in the community at the earliest opportunity.

The preventive components of community mental health programs electively focus upon individuals at special risk in the population who may become "targets" for particular services or attention. Predictable life crises and maturational stresses help to identify these individuals in the community. These points of potential emotional disequilibrium cover a wide range of experience, including, for example, serious illness, surgical operation, pregnancy, premature birth of an infant, marriage, death of a family member, induction into the Armed Services or the Peace Corps, or relocation or retirement. The appropriate "helping" interventions for these different crises are varied, ranging from observation, support, providing certain supplies, education, anticipatory guidance, encouraging social organization or action, consultation with other helpers or crisis therapy. Those directing programs must also be alert to noxious or harmful factors which may contribute to mental illness, including awareness of various social, cultural, economic and legal factors of stress as they impinge upon the community.

In most programs, small professional staffs will be confronted with an overwhelming responsibility. Therefore, those responsible for each program must determine how to best address their efforts to this assignment. Traditionally, the community expects that mental health programs will provide direct diagnostic and psychiatric treatment services to persons in need. However, initially a significant amount of attention may be devoted to determining what psychiatric and non-psychiatric helping agencies, groups and individuals are already dealing with these problems. Mental health programs may be started with the provocative position that it is essential that none of these helping agencies relinquish their current roles in the mental health complex. Rather, these groups are asked to consider how the mental health services program might help them in their continued shouldering of this responsibility.

Frequently, when activities of these programs are shared and reviewed, it is mutually concluded that the mental health needs of the client are being met and that direct treatment intervention of the mental health team is not indicated. In this way, a pattern may be established whereby various community groups who have an important first-line relationship with individuals in crisis, in emotional conflict or in psychiatric illness turn to the mental health program, asking to *confer* about their "problem" rather than requesting that their clients receive psychiatric treatment. The caretakers who request services from the *mental health consultation* division of a community program may include, for example, the police, lawyers, public health nurses, social workers, the clergy, educators and the schools, hotel operators, housing project officials, probation officers, general physicians, welfare departments and employment counselors.

Briefly, the goal of mental health consultation described by a number of authors[1,2,3] is to help these community caretakers in their current work with their clients, many of whom have serious psychiatric problems. When a worker from an agency or community program consults with a mental

health professional, he is, if the consultation proves helpful, acquiring understanding and skill in dealing with a number of cases which can be anticipated to come his way in the future. Herein lies the relevance, the importance and the economy of the mental health professional's investment in the consultation service. The consultant focuses upon problems that the person consulting him is having in work with his client. From the consultation the person who is seeking advice should be better able to function within the role of his particular job setting. The purpose is to help him carry out his teaching, policing, probation or other role more satisfactorily—not try to make of him a sort of "junior psychiatrist" or other mental health expert. Through this kind of help to community caretakers, a significant number of troubled or needy persons who are being dealt with by the caretakers are kept from becoming materialized psychiatric casualties who must enter the direct service treatment facilities of community mental health programs.

Community programs also traditionally include provision for psychiatric consultations to physicians concerning the emotional problems of their patients. Physicians, both general practitioners and specialists, are at present coping with the major burden of mental illness in the community. Often with help from psychiatric consultation, general practitioners can be encouraged to continue in the demanding and frustrating care of patients with chronic psychiatric illness. Often for such patients the general practitioner is the most appropriate source of help. Current planning of community mental health centers emphasizes increased direct participation by physicians from general practice.

To provide the variety of direct and indirect service approaches described to this point, many pertinent elements in a community must be drawn together in a shared program. This will involve the integration of existing hospital and clinic services, government agencies, public health and private approaches into a coordinated operation consistent with the goals of the program and the resources of the community.

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REFERENCES

1. Berlin, I. N.: Learning Mental Health Consultation: History and problems. Mental Hygiene, 48:257-266, April 1964.

2. Caplan, Gerald: Principles of Preventive Psychiatry, Basic Books, New York, pp. 232-265, 1964.

3. Haylett, Clarice H., and L. Rapoport: Mental Health Consultation. From Bellak's Handbook of Community Psychiatry, Grune and Stratton, Inc., New York, pp. 319-339, 1964.